CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155618		IDENTIFICATION NUMBER:	A. BUILDING 01		01	COMPLETED		
		155618	B. WING			08/17/2011		
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
MANOD	CADE UEALTU SE	RVICES SUMMER TRACE			N PENNSYLVANIA STREET			
IVIAINOR	CARE HEALIH SE	RVICES SUMMER TRACE		CARIVIE	EL, IN46032			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	RRECTION (X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	Pl	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE	
K0000								
'	A Life Safety Co	ode Recertification and	K0000		The statements made in this Pla	n of		
	1	Survey was conducted by			Correction are not an admission	i to		
		e Department of Health in			and do not constitute an agreem			
		•			with the alleged deficiencies he			
	accordance with	42 CFR 483.70(a).			To remain in compliance with a			
					federal and state regulations, the			
	Survey Date: 08	3/17/11			center has taken or is planning	.0		
					take the actions set forth in the	1		
	Facility Number	: 001149			following Plan of Correction. T			
	Provider Numbe				Plan of Correction constitutes the center's allegation of compliance. All			
	AIM Number: 200145500				alleged deficiencies cited have			
	7 THIN TURNOCT. 2	or are to be corrected by the date of						
	C Ma. 1	Complement if a Conference			dates indicated.	Cor		
	Surveyor: Mark Caraher, Life Safety							
	Code Specialist	Specialist						
	At this Life Safe	ety Code survey, Manor						
	Care Health Serv	vices Summer Trace was						
	found not in con	nnliance with						
		or Participation in						
		eaid, 42 CFR Subpart						
		*						
	` ' '	Safety from Fire and the						
	2000 Edition of	the National Fire						
	Protection Assoc	ciation (NFPA) 101, Life						
	Safety Code (LS	SC), Chapter 19, Existing						
	Health Care Occupancies and 410 IAC 16.2.							
	10.2.							
	This two story for	acility was determined to						
	This two story facility was determined to be of Type I (332) construction and fully sprinklered. The facility has a fire alarm							
	system with smo	oke detection in the						
	corridors, all are	as open to the corridor						
	and all resident sleeping rooms. The							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MZMC21

Facility ID:

001149

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155618 08/17/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 12999 N PENNSYLVANIA STREET MANOR CARE HEALTH SERVICES SUMMER TRACE CARMEL, IN46032 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE facility has a capacity of 93 and had a census of 76 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/23/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: One hour fire rated construction (with 3/4 hour K0029 fire-rated doors) or an approved automatic fire SS=E extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 K 029 SS=E NFPA 101 Life Safety K0029 09/16/2011 Based on observation and interview, the Code Standard facility failed to ensure 4 of 6 doors on the first floor serving hazardous areas such as It is the practice of this center to the kitchen and storage rooms greater than comply with K 029 NFPA 101 Life fifty square feet in size used to store Safety Code Standard combustible materials are each equipped What corrective action(s) will be with self closing devices which cause the accomplished for those residents door to close and latch the door into the found to have been affected by the door frame. This deficient practice could deficient practice; affect any resident, staff or visitor in the No residents were affected. The 4 vicinity the first floor kitchen and the first doors identified now self close and floor nursing supply room. latch the door in to the door frame.

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 01	(X3) DATE COMPI 08/17/2	ETED
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA STREET CARMEL, IN46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3 NATE	(X5) COMPLETION DATE
	Environmental I Maintenance Dir facility from 12: 08/17/11, the no the corridor and southeast kitcher room are each provided with a to latch each door Based on intervity observation, the acknowledged thand southeast kir equipped with a to latch each door b. Based on observation because of the southeast kir equipped with a to latch each door b. Based on observation because of the southeast kir equipped with a to latch each door b. Based on observation because of the southeast kir equipped with a to latch each door b. Based on observation and the southeast kir equipped with a to latch the door in on interview at the southeast kir equipped with a door which woullatch the door in on interview at the southeast kir equipped with a door which woullatch the door in on interview at the southeast kir equipped with a door which woullatch the door in on interview at the southeast kir equipped with a door which woullatch the door in on interview at the southeast kir equipped with a door which woullatch the door in on interview at the southeast kir equipped with a door which woullatch the door in on interview at the southeast kir equipped with a to latch each door because of the southeast kir equipped with a to latch each door because of the southeast kir equipped with a door which woull at the door in on interview at the southeast kir equipped with a to latch each door because of the southeast kir equipped with a to latch each door because of the southeast kir equipped with a to latch each door because of the southeast kir equipped with a to latch each door because of the southeast kir equipped with a to latch each door because of the southeast kir equipped with a to latch each door because of the southeast kir equipped with a to latch each door because of the southeast kir equipped with a to latch each door because of the southeast kir equipped with a to latch each door because of the southeast kir equipped with a to latch each door because of the southeast kir equipped with a to latch each door because of the southeast ki	ervations with the Director and the rector during a tour of the 35 p.m. to 2:40 p.m. on rthwest kitchen door to the southwest and a doors to the dining rovided with a self closing or, but each door is not positive latching device or into the door frame. ew at the time of Maintenance Director are northwest, southwest techen doors are each not positive latching device or into the door frame. ervation with the Director and the rector during a tour of the 35 p.m. to 2:40 p.m. on set floor nursing supply 190 square feet and is posable briefs in			How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken; No residents were affected. It doors identified now self closs latch the door in to the door for the what measures will be put in place or what systemic change will be made to ensure that the deficient practice does not remain the made to ensure that the deficient practice does not remain the mount of the frame. How the corrective action(s) be monitored to ensure the deficient practice will not refice, what quality assurance program will be monitored weel weeks by Environmental Serv Director or Designee to ensure are still self closing and latched the door frame. The results of the audit will be submitted to the QA&A Comfor further review and recommendations. By what date the systemic clavilla be completed: September 16, 2011.	ce: ckly x 4 rices e doors ing in to e mittee	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155618		(X2) MUL A. BUILD B. WING		01	(X3) DATE S COMPL 08/17/20	ETED		
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA STREET CARMEL, IN46032					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
K0050 SS=C	the first floor nurmeasured greater used to store commot equipped with the door. 3.1-19(b) Fire drills are held varying conditions shift. The staff is the is aware that drills routine. Responsi conducting drills is competent person exercise leadershic conducted between announcement manualible alarms. 1. Based on record the facility failed drills at unexpect conditions on the quarters. This deall occupants in the residents, staff and the conditions on the guarters, staff and the conditions on the guarters.	at unexpected times under at least quarterly on each amiliar with procedures and are part of established bility for planning and assigned only to s who are qualified to p. Where drills are n 9 PM and 6 AM a coded by be used instead of 19.7.1.2 and review and interview, to conduct quarterly fire the times under varying at third shift for 4 of 4 efficient practice affects he facility including and visitors.	K00			nfety Life be uts	DATE 09/16/2011	
	documentation w Director and the	of "Fire Alarm Report" with the Environmental Maintenance Director o 12:05 p.m. on 08/17/11,			Mo residents were affected. The Drills will be conducted at unexpected times and varying conditions and a coded announcement will only be used.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155618		A. BUII	LDING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/17/2011		
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE			B. WING 06/17/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA STREET CARMEL, IN46032				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	between 9pm and 6am and	DATE	
		shift fire drills conducted 0 and 07/15/11 were			documentation will accurately	reflect	
		en 11:01 a.m. and 11:10			all Fire Drills conducted.		
		nterview at the time of			 		
	record review, th				How other residents having the potential to be affected by the		
	-	owledged third shift fire			same deficient practice will be	<u> </u>	
	-	onducted at unexpected			identified and what corrective	<u>e</u>	
	times under vary	•			action(s) will be taken;		
					No residents were affected. The	ne Fire	
	3.1-19(b)2. Based on record review and interview, the facility failed to document the				Drills will be conducted at		
					unexpected times and varying		
					conditions and a coded	,	
					announcement will only be use between 9pm and 6am and	ed	
	transmission of the fire alarm signal for 2				documentation will accurately	reflect	
	of 2 fire drills conducted prior to 9:00				all Fire Drills conducted.		
		nd shift for 1 of 4			What measures will be put in	<u>to</u>	
	-	9.7.1.2 states fire drills in			place or what systemic chang		
	•	pancies shall include the			will be made to ensure that th	_	
	_	he fire alarm signal and			deficient practice does not red Maintenance Staff has beer		
		ergency fire conditions.			re-educated that The Fire D		
	This deficient pra				will be conducted at unexpe	cted	
	_	facility including			times and varying conditions		
	residents, staff ar				a coded announcement will be used between 9pm and 6		
	residents, stair ar	id visitors.			and documentation will accu		
	Findings include				reflect all Fire Drills conduct	- I	
						201	
	Based on review	of "Fire Alarm Report"			How the corrective action(s) to be monitored to ensure the	<u>WIII</u>	
	documentation w	ith the Environmental			deficient practice will not rec	ur,	
	Director and the	Maintenance Director			i.e., what quality assurance		
	from 9:30 a.m. to	o 12:05 p.m. on 08/17/11,			program will be put into plac		
		or two second shift fire			Fire Alarm Reports will be mo	nitored	
	drills conducted	prior to 9:00 p.m. during			Monthly x 3 months by Environmental Services Direct	or or	
	· ·	r on 10/07/10 at 8:30			Designee to ensure that the Fir		
	*	5/10 at 5:16 p.m. did not			Drills are conducted at unexpe		

001149

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155618		A. BUII	LDING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/17/2011	
NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE		B. WIN	STREET A 12999 N	DDRESS, CITY, STATE, ZIP CODE I PENNSYLVANIA STREET IL, IN46032	33/1//2011	
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OR include the transis signal. Based on record review, the stated the fire alabut acknowledge fourth quarter seconducted prior to	mission of the fire alarm interview at the time of e Environmental Director rm system was activated d documentation of cond shift fire drills o 9:00 p.m. did not sion of the fire alarm		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) times and varying conditions an coded announcement is only use between 9pm and 6am and documentation accurately reflect Fire Drills conducted. The results of the audit will be submitted to the QA&A Common for further review and recommendations. By what date the systemic changing between 16, 2011.	nd a ed ets all ittee
K0144 SS=F	exercised under lo month in accordar 3.4.4.1. Based on observation facility failed to a generators was emanual stop. NF Facilities, 3-4.1.1 installed as alternated the requirer Standard for Emeror Systems. NFPA Level II installation manual stop statistic break glass station room where the properties of the Installation Combustion English.	spected weekly and ad for 30 minutes per ince with NFPA 99. ation and interview, the ensure 1 of 1 emergency equipped with a remote PA 99, Health Care 1.4 requires generator sets nate power sources shall ments of NFPA 110, ergency Standby Power 110, 3-5.5.6 requires one shall have a remote on of a type similar to a conflocated outside of the prime mover is located. States NFPA 37, Standard on and Use of Stationary ines and Gas Turbines, ory requirements for	KC	0144	K 144 SS=F NFPA 101 Life Sa Code Standard It is the practice of this center to comply with K 144 NFPA 101 I Safety Code Standard What corrective action(s) will accomplished for those resider found to have been affected by deficient practice; No residents were affected. The emergency generator will be equipped with a remote manual How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	be_ nts_ / the e stop.

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	01	COMPLETED		
		155618	B. WIN	IG		08/17/2011	
NAME OF F	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
The state of the s			12999 N PENNSYLVANIA STREET				
MANOR	CARE HEALTH SEI	RVICES SUMMER TRACE		CARME	EL, IN46032		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	emergency gener	rators and shall be					
	considered part of	of the requirements of this		No residents were affected. The		e	
	standard. NFPA	37, 8-2.2(c) requires			emergency generator will be equipped with a remote manual	ston	
	emergency gener	rators of 100 horsepower			What measures will be put int	· 1	
		visions for shutting			place or what systemic change	- 1	
	•	at the engine and from a			will be made to ensure that the	_	
	_	This deficient practice			deficient practice does not rec		
		esidents, staff and			Maintenance Staff has been		
		concerts, start allu			re-educated that emergency		
	visitors.				generator will be equipped w remote manual stop.	rith a	
					remote manuai stop.		
	Findings include	:			How the corrective action(s) w	rill	
					be monitored to ensure the		
	Based on observa	ation with the			deficient practice will not recu	<u>r,</u>	
	Environmental D	irector and the			i.e., what quality assurance		
	Maintenance Dir	ector during a tour of the			program will be put into place	<u>:</u>	
	facility from 12:3	35 p.m. to 2:40 p.m. on			Emergency Generator Remote		
	=	lence of a remote shut off			Manual Stop placement will be		
		I for the 400 KW diesel			monitored Monthly x 1 month t Environmental Services Director	- 1	
		generator. Based on			Designee to ensure emergency	01 01	
		ime of observation, the			generator is equipped with a rer	mote	
					manual stop.		
	Maintenance Dir				·		
		ator was installed prior to			The results of the audit will be		
		vledged there is no			submitted to the QA&A Comm	ittee	
	remote emergence	y shut off device for the			for further review and		
	generator.				recommendations.		
					By what date the systemic cha	nges	
	3.1-19(b)				will be completed;		
					September 16, 2011.		
					· · · · · · · · · · · · · · · · · · ·		